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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0074	A. BUILDING _____ B. WING _____	R 03/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CARE	2820 HARTFORD STEET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 000)	INITIAL COMMENTS A follow-up licensure inspection was conducted from 3/20/2008 through 3/21/2008 to assess compliance with the findings from the 2/4/08 initial licensure survey. Two males and four females with varying degrees of disabilities reside in the facility. All five residents were selected to be included in the survey ' s sampling. The findings were based on observations at the group home, interviews with the GHMRP ' S staff, and the review of records including the incident reports. An initial licensure survey was initiated on January 31, 2008 and completed on February 4, 2008. A random sample of three clients was selected from a population of four female residents and two males residents with varying degrees of mental retardation and other disabilities. The findings of the survey were based on observations at the residence and two day programs. Also the findings were based on management and direct care staff in the residential and day program, as well as a review of habilitation and administrative records, to include the facility's unusual incident reporting system.	(I 000)	Received 4/15/08 UPM GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 024	3501.7 ENVIRONMENTAL REQ / USE OF SPACE Each GHMRP shall show that it can provide outside recreational activities. This Statute is not met as evidenced by: Based on staff interview and record review, the	I 024	3501.7 All individuals have at least four community recreational activities per month. These were documented, however the planned recreation calendar could not be located. In the future the home manager will make sure that each individual has a recreation calendar in their program book. The QMRP will ensure that there is a calendar and there are at least 4 activities per month.	4/11/08

Health Regulation Administration

Paul Hang
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 4/15/08

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I 024	Continued From page 1 GHRMP failed to enact measures to ensure its residents received consistent access to outside recreational activities for all Residents residing in the facility. The findings include: On 3/20/2008, the Group Home for Mentally Retarded Persons (GHMRP) ' s Quality Assurance Specialist was not able to provide any evidence that outside recreational activities had been arranged and/or scheduled for any of the six resident ' s of the facility. On 3/21/2008 the Program Coordinator (PC) failed to present any evidence that measures had been taken to ensure that all of its six residents had access to take part in outside recreational activities.	I 024		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that staff received the proper training and instruction in meal preparations and provisions for all Residents residing in the facility. The finding includes: 1. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended that staff " encourage adequate fluid intake (6-8 cups/day) " . On 3/21/08 at 4:47pm, the facility ' s Program	I 042	3502.2 1. New documentation method is in place to indicate number of fluids consumed. Staff have been trained on hydration. In the future the program coordinator and the nurses will check the fluid intake and do meal monitoring to ensure adequate fluid intake for all individuals.	3/24/08

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I 042	Continued From page 2 Coordinator (PC) indicated that the GHMRP's staff was taking the necessary measures to ensure that Resident #1 received at least 8oz of fluids during each meal. Record review revealed her most recent lab results indicated she had an abnormally elevated BUN count due to dehydration. At 4:56pm on the same day, the PC presented data that shows staff was documenting that Resident #1 was offered fluids on each meal, but the data being collected did not indicate the amount of cups or fluid ounces per day she ' s consuming. There was no evidence on file or presented during the survey to substantiate that staff had received any training or instructions from the Nutritionist to ensure Resident #1 ' s fluid intake requirements. 2. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended and supported the current dietary order for " regular [diet] with ground texture, double portions, and increased fiber/liquid nutritional supplement 3 times daily. Observations on 3/20/2008 at 4:49pm revealed Resident #1 ' s food portions were the same as Resident #2 ' s. Resident #1 was not observed to be offered seconds at any time during the evening meal times. There was no evidence on file or presented during the survey to substantiate that staff had received any training or instructions from the Nutritionist to ensure Resident #1 ' s recommended " double portions " .	I 042	2. Staff have been trained on portion sizes and are now implementing correct portion sizes per orders. Program coordinator, home manager and nurses are doing weekly meal monitoring to ensure that correct portions are served.	3/24/08
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.	I 056		

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I 056	Continued From page 3 This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the sanitary conditions of cooking and serving equipment for all Residents residing in the facility. The finding includes: During the environmental inspection on 3/20/2008 at 4:17pm several plastic serving bowls being stored in the cabinet above the sink were found with food residue and dried grease stains. In addition, the cooking surface of several cooking and baking pans was found to be extremely worn and/or rusted. The facility ' s Program Coordinator was interviewed on 3/21/2008 at 5:56pm and she indicated she was not aware there was soiled plates/bowls being stored in the cabinets. She further indicated that all cooking and dinner ware should have been maintained, cleaned and stored properly. There was no evidence presented at the time of survey to substantiate that staff had been trained to properly care for any of the eating and cooking equipment as required by this section.	I 056	3502.14 All dishes and cooking utensils have been cleaned or replaced. Staff have been trained on proper care of cooking and eating equipment. The home Manager will do a monthly audit of kitchen equipment to make sure that equipment is clean and in proper condition.	4/11/08
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation and staff interview, the	I 058		

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I 058	Continued From page 4 facility failed to enact and enforce the necessary measures to ensure the proper and necessary Nutritional oversight for its residents. (Example: Resident #1) The finding includes: 1. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended that staff " encourage adequate fluid intake (6-8 cups/day) " . On 3/21/08 at 4:47pm, the facility ' s Program Coordinator (PC) indicated that the GHMRP's staff was taking the necessary measures to ensure that Resident #1 received at least 8oz of fluids during each meal. Record review revealed her most recent lab results indicated she had an abnormally elevated BUN count due to dehydration. At 4:56pm on the same day, the PC presented data that shows staff was documenting that Resident #1 was offered fluids on each meal, but the data being collected did not indicate the amount of cups or fluid ounces per day she ' s consuming. There was no evidence on file or presented during the survey to substantiate that the Group Home for Mentally Retarded Persons (GHMRP) coordinated the proper oversight with the Nutritionist to ensure Resident #1 ' s fluid intake requirements. 2. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended and supported the current dietary order for " regular [diet] with ground texture, double portions, and increased fiber/liquid nutritional supplement 3 times daily. Observations on 3/20/2008 at 4:49pm revealed Resident #1 ' s food portions were the same as Resident #2 ' s. Resident #1 was not observed to be offered seconds at any time during the evening meal times. There was no evidence on	I 058	3502.16 1. New documentation method is in place to indicate number of fluids consumed. Staff have been trained on hydration. In the future the program coordinator and the nurses will check the fluid intake and do meal monitoring to ensure adequate fluid intake for all individuals. 2. Staff have been trained on portion sizes and are now implementing correct portion sizes per orders. Program coordinator, home manager and nurses are doing weekly meal monitoring to ensure that correct portions are served.	3/24/08 3/24/08

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I 058	Continued From page 5 file or presented during the survey to substantiate that the Group Home for Mentally Retarded Persons (GHMRP) coordinated the proper oversight with the Nutritionist to ensure Resident #1 ' s recommended " double portions ".	I 058		
I 062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the sanitary conditions of all eating/serving utensils for all Residents residing in the facility. The finding includes: During the environmental inspection on 3/20/2008 at 4:17pm several plastic serving bowls being stored in the cabinet above the sink were found with food residue and dried grease stains. In addition, the cooking surface of several cooking and baking pans was found to be extremely worn and/or rusted. The facility ' s Program Coordinator was interviewed on 3/21/2008 at 5:56pm and she indicated she was not aware there was soiled plates/bowls being stored in the cabinets. She further indicated that all cooking and dinner ware should have been maintained, cleaned and stored properly. There was no evidence presented at the time of survey to substantiate that the Group Home for Mentally Retarded Persons (GHMRP) had enacted the necessary systems to ensure the proper care and maintenance of the eating and cooking	I 062	3502.20 All dishes and cooking utensils have been cleaned or replaced. Staff have been trained on proper care of cooking and eating equipment. The home Manager will do a monthly audit of kitchen equipment to make sure that equipment is clean and in proper condition.	4/11/08

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I 062	Continued From page 6 equipment as required by this section.	I 062		
I 073	3503.3(b) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (b) Clean comfortable pillow; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure that its Resident ' s be provided with clean pillows. (Examples: Residents #4 & #6) The finding includes: During the environmental inspection on 3/20/2008 at 3:18pm revealed Resident #4 and 6 ' s pillows and comforters were soiled with what appeared to be bodily fluids. Interview with the facility ' s Program Coordinator on 3/21/2008 at 3:57pm revealed she was not aware of the poor sanitary conditions of the pillows and bedspreads in the home. [Reference the citations of poor sanitary conditions cited in 3502.14, 3502.20, 3504.1 & 3504.9]	I 073	3503.3(b) All beddings for all individuals have been washed. The home manager and program coordinator will do weekly checks to ensure that all individuals bedrooms have adequate and clean pillows and linens.	4/5/08
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and staff interview, the	I 082	3503.10 All bathrooms now have cups and dispensers. In future the home manager will do daily walk through and monthly audits to ensure that all bathrooms have cups and dispenser. The program coordinator will provide oversight to ensure that all individuals have adequate supplies of cups and needed bathroom items.	4/15/08

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I 082	Continued From page 7 facility failed to enact and enforce the necessary measures to ensure all bathrooms are equipped and properly stocked with cup dispensers and paper towels for all Residents residing in the facility. The finding includes: During the environmental inspection on 3/20/2008 at 3:33pm revealed none of the resident ' s bathrooms had cups available in the cup dispensers. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 5:37pm revealed she was not aware of the empty cup dispensers.	I 082		
{I 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of this regulatory requirement. The finding includes: The following citations were observed during the environmental inspection on 3/21/2008 at 3:10pm: 1. Resident #2 ' s hospital bed was inoperable. Interview with the facility ' s Licensed Practical Nurse (LPN) on 3/21/2008 at 5:14pm revealed	{I 090}	3504.1 1. Resident #2's bed has been replaced.	4/15/08

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(I 090)	Continued From page 8 Resident #2 was prescribed the hospital bed due to risks of aspiration, gastritis, and history of bronchitis. The facility failed to ensure the maintenance of this resident ' s adaptive equipment. 2. There was water damage along the wall in Resident #2 ' s bedroom. There were also areas along the floor to wall joints in the closets that were dark, fuzzy and appeared to be mold. 3. In Bathroom #1, water damage and broken tiles were observed along the lower portion of the floor adjacent to Resident #2 ' s bedroom. 4. The walls near Resident #3 ' s bed were smeared with a brown substance. During the walk-thru, the Direct Care Staff indicated that Resident #3 was known to smear his feces and they were not aware that those stains were on the walls near his bed. 5. The small window in the door in the dining area was broken. This was an exterior door and the crack was covered with plastic bags and scotch tape. 6. The screen in Resident #4 ' s room was missing. The facility failed to ensure that all the screens in all the windows were in good shape. 7. The small wooden area that houses the garbage was overflowing. The garbage was piled up over the garbage cans and food items were observed on the ground around the base of the garbage cans.	(I 090)	2. Repairs to the bedroom wall have been made and the closet wall joints have also been repaired. 3. Water damage and broken tiles in bathroom #1 have been repaired. 4. Walls in Resident #3's room have been cleaned and disinfected. 5. The window in the door of the dinning room will be repaired by . 6. All screens have been replaced in all the bedrooms 7. The garbage area has been thoroughly cleaned. In future the home manager will conduct a comprehensive environmental audit on a monthly basis and all necessary repairs done in a timely manner. The program coordinator will ensure that audit is done and all repairs done timely.	4/15/08 4/15/08 3/24/08 4/30/08 4/11/08 3/20/08 4/30/08
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in	I 095		

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I 095	Continued From page 9 a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper storage of all caustic agents. The finding includes: [Reference citation 3504.7]	I 095	See 3504.6 3504.7	
I 096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure that poisonous and/or hazardous agents are stored or kept in a food preparation environment (kitchen). The finding includes: During the environmental inspection on 3/20/2008 at 3:39pm revealed cleaning agents were being stored in kitchen. Interview with the facility ' s Program Coordinator on 3/21/2008 at 3:44pm revealed she was not aware the cleaning agent was being stored in the kitchen. She further added that those items should have been locked away.	I 096	All cleaning agents have been removed from the kitchen area and placed in a locked cabinet. Home manager and program coordinator will perform daily walk through to ensure there are no cleaning agents in the kitchen and home manager will do monthly environmental audits to ensure that cleaning agents are properly stored.	3/22/08

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I 098	Continued From page 10	I 098		
I 098	3504.9 HOUSEKEEPING Each GHMRP shall provide appropriate procedures, personnel, and equipment in order to ensure sufficient clean linen supplies and the proper sanitary washing and handling of linen and personal clothing of each resident. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure all Residents bedding are furnished with clean linen. (Examples: Residents #4 & #6) The finding includes: During the environmental inspection on 3/20/2008 at 3:18pm revealed Resident #4 and 6 ' s pillows and comforters were soiled with what appeared to be bodily fluids. Interview with the facility ' s Program Coordinator on 3/21/2008 at 3:57pm revealed she was not aware of the poor sanitary conditions of the pillows and bedspreads in the home. The facility failed to ensure the proper and necessary systems were enacted to ensure the washing and sanitary conditions of the linen as required by this section. [Reference the citations of poor sanitary conditions cited in 3502.14, 3502.20, 3503.3, 3504.1]	I 098	3504.9 All dishes and cooking utensils have been cleaned or replaced. Staff have been trained on proper care of cooking and eating equipment. The home Manager will do a monthly audit of kitchen equipment to make sure that equipment is clean and in proper condition.	3/24/08
I 100	3504.10(b) HOUSEKEEPING Each GHMRP shall provide clean linens as follows to each resident at least weekly: (b) One (1) pillowcase; This Statute is not met as evidenced by:	I 100	3504.10(b) All dishes and cooking utensils have been cleaned or replaced. Staff have been trained on proper care of cooking and eating equipment. The home Manager will do a monthly audit of kitchen equipment to make sure that equipment is clean and in proper condition.	4/11/08

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I 100	Continued From page 11 Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provision of clean linen/bedding to all Residents. The finding includes: [Reference the citations of poor sanitary conditions cited in 3502.14, 3502.20, 3503.3, 3504.1 & 3504.9]	I 100		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure its Residents were provided with an adequate supply of clothing. (Examples: Residents #1, #2,& #6) The finding includes: Observation on 3/20/2008 and again on 3/21/2008 revealed Resident #1, #2, and #6 had approximately one to two pairs of shoes, no casual and/or formal dress wear and none of the clothing appeared properly coordinated. Interview with the facility ' s Direct Care Staff on 3/20/2008 at 3:01pm revealed all three residents could be provided additional clothing and they would also ensure better care of what was there as well.	I 108	3504.15 All residents have had clothing inventory done. All individuals' who need additional clothing and shoes will be assisted to go to the mall and purchase needed items by. Home Manager will conduct inventory checks at least 2 times a year and needed items purchased. Program coordinator will provide oversight to ensure that bi-annual inventories are done and all individuals have adequate clothing.	4/30/08

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	HFD12-0074	A. BUILDING _____ B. WING _____	R 03/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CARE	2820 HARTFORD STEET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 123	Continued From page 12	I 123		
I 123	3505.4(a)(1) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (1) The instructions and plans that are to be followed in case of fire, explosion, or other emergency: This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy to manage the instructions and plans that are to be followed in case of fire, explosion, or other emergency. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the necessary system and/or protocol had been created and/or implemented to ensure that this requirement had been met. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:23pm revealed that part of the policy was not available at the time of survey.	I 123	3505.4(a)(1) 1. There is a disaster plan in place, however Capital Care administrator is in the process of creating a fire safety plan. Training will be provided to staff by .	4/30/08
I 124	3505.4(a)(2) FIRE SAFETY Each GHMRP shall have on the premises the following items:	I 124	3505.4(a)(2) There's a notification policy in the Emergency disaster policy. (see emergency disaster plan). However the administrator will ensure that the new Fire safety Policy address notification. This will be completed by.	4/30/08

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FORM APPROVED

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I 124	Continued From page 13 (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (2) The persons to be notified; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy to address the person to be notified in the event of a fire/emergency. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the necessary system of notification had been created and/or implemented to ensure that this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:25pm revealed that part of the policy was not available at the time of survey.	I 124		
I 125	3505.4(a)(3) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following:	I 125	3505.4(a)(3) The administrator is in the process of developing policies that address location of the alarm signals.	4/30/08

PRINTED: 04/04/2008
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I 125	Continued From page 14 (3) The location of alarm signals; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy or posting that identified the location of alarm signals. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that this requirement had been met. This policy requirement was not met at the time of inspection. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:27pm revealed that part of the policy was not available at the time of survey.	I 125		
I 126	3505.4(a)(4) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (4) The locations of fire extinguishers; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary	I 126	3505.4(a)(4) Written polices and procedures that are approved by the Fire Chief are being developed and will be available to staff and residents. The policy will include fire extinguishers.	4/30/08

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I 126	Continued From page 15 measures to ensure the provisions of a policy or posting which identified the location of fire extinguishers. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that this requirement had been met. This policy requirement was not met at the time of inspection. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:29pm revealed that part of the policy was not available at the time of survey.	I 126		
I 127	3505.4(a)(5) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following; (5) The evacuation routes; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy or posting that identified the assigned evacuation routes in the event of a fire/emergency. The finding includes: The Group Home for Mentally Retarded Persons	I 127	3505.4(a)(5) Written polices and procedures that are approved by the Fire Chief are being developed by the administrator and will include evacuation routes. This will be done by.	4/30/08

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I 127	Continued From page 16 (GHMRP) failed to present any evidence at the time of survey to substantiate that necessary system had been enacted to ensure that this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:31pm revealed that part of the policy was not available at the time of survey.	I 127		
I 128	3505.4(a)(6) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (6) The frequency of fire drills; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy which governs the frequency of fire drills. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the necessary system had been enacted to ensure that this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:33pm revealed that part of the policy was not available	I 128	3505.4(a)6 Written polices and procedures that are approved by the Fire Chief are being developed by administrator and will include the frequency of Fire drills..	4/30/08

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I 128	Continued From page 17 at the time of survey.	I 128		
I 129	3505.4(a)(7) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (7) The assignment of specific tasks and responsibilities to the staff of each shift; and... This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of a policy which governed the assignment of specific tasks and responsibilities for all staff across all shifts. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper and necessary training had been implemented to ensure that this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:36pm revealed that part of the policy was not available at the time of survey.	I 129	3505.4(a)(7) Written polices and procedures that are approved by the Fire Chief are being developed by the administrator and will include assignment of specific tasks and responsibilities of the staff on each shift. Training will be implemented by.	4/30/08
I 131	3505.4(b) FIRE SAFETY Each GHMRP shall have on the premises the	I 131	3505.4(b) The administrator is working on new policies and staff will receive appropriate training to ensure that Fire safety measures are implemented by all staff.	4/30/08

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I 131	Continued From page 18 following items: (b) Records of the training of all personnel who are to perform the specific tasks designated in the manual described in paragraph (a) of this subsection; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper documentation and record keeping of all staff training. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper and necessary training was being conducted to ensure this requirement had been met. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:40pm revealed that evidence of staff training was not available at the time of survey.	I 131		
I 132	3505.4(c) FIRE SAFETY 3505.4 Each GHMRP shall have on the premises the following items: (c) Records of fire inspection reports; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper record keeping and documentation of all fire inspection reports. The finding includes:	I 132	3505.4 Fire inspector performed an inspection on January 31st, but Capital Care does not have a report of the visit. Capital Care will contact the Fire Marshall and get the report to filed in the home.	4/30/08

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I 132	Continued From page 19 The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper record keeping was being enforced to ensure this requirement had been met. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:45pm revealed she was not able to locate the most recent fire inspection report at the time of survey.	I 132		
I 133	3505.4(d) FIRE SAFETY Each GHMRP shall have on the premises the following items: (d) Dates of the test of alarm appliances; and... This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper record keeping and documentation of all testing of alarm equipment. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper record keeping was being enforced to ensure this requirement had been met. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:50pm revealed that there was no evidence that the alarm equipment had been tested as required by this section.	I 133	3505.4(d) The test of the alarm appliances was performed, however Capital care does not have the report. Capital Care will contact Alarm works to get a copy of the report by. In future, capital care will maintain a log and folder that holds all inspections from alarm company.	4/30/08
(I 140)	3506.1(a) PROGRAM STATEMENT Each GHMRP shall have a written statement of	(I 140)		

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goals which following:	(I 140)		
iidents to be		3506.1(a)	
nced by: nterview, the the necessary d procedure pproved by the ght committee.		Capital care now has a policy and procedure manual that has been reviewed and approved by the administrator.	4/1/08
tarded Persons vidence at the it the proper ed to ensure this facility failed to the agency's and the number l. Interview with ator on s section of the not available at			
RES	I 161	3507.2	
governing be reviewed at		Capital care now has a policy and procedure manual that has been reviewed and approved by the administrator.	4/30/08
This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the policy and procedure manual had been reviewed and approved by the			

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I 161	Continued From page 21 facility ' s administrator or oversight committee. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper record keeping was being enforced to ensure this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:01pm revealed the policy and procedure manual was not signed nor dated as being reviewed over the past certification year.	I 161		
(I 166)	3507.4(d) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (d) Record keeping, which covers resident records, administrative records, and confidentiality of records; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure that the current policy and procedure manual addressed the record keeping of all resident and administrative records to ensure confidentiality. The finding includes: The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper system had been enacted to enforce accurate record keeping ensuring this requirement had	(I 166)	3507.4(d) Capital care now has a policy and procedure manual that has been reviewed and approved by the administrator.	4/30/08

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(I 166)	Continued From page 22 been met. This policy requirement was not met at the time of inspection. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 6:05pm revealed that part of the policy was not available at the time of survey.	(I 166)		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the scheduling of staff training. The finding includes: Staff interview and record review on 3/21/2008 revealed the facility failed to ensure the proper and necessary training and supported to the staff to ensure the effective treatment and habilitation as recommended in the Individual Service Plans of all six residents. Interview with the facility ' s Residential Coordinator on 3/21/2008 at 3:22pm revealed the scheduled trainings were not available for review at the time of survey. [Examples of this deficient practice are referenced in 3519.2 and 3520.6]	I 222	3510.3 There's a training book and training schedule available. Staff has been trained in a number of areas including medical, ISP goals and objectives, BSPs, infection control signs and symptoms of illness among many. There must have been miscommunication as this was available in the home for review.	3/21/08
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by:	I 260	3512.1 See 3505.4(a)(1), 3505.4(a)(2), 3505.4(a)(3), 3505.4(a)(4), 3505.4(a)(5), 3505.4(a)(6), 3505.4(a)(7),3505.4(a)(b), 5305.4(b), 3505.4(c), 3505.4(d), 3507.2, 3507.4 and 3508.2.	4/30/08

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I 260	Continued From page 23 Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provisions of this regulatory requirement as evidenced below. The finding includes: Reference the citations in the areas of record keeping as cited in 3505.4(a)(1), 3505.4(a)(2), 3505.4(a)(3), 3505.4(a)(4), 3505.4(a)(5), 3505.4(a)(6), 3505.4(a)(7), 3505.4(a)(8), 3505.4(b), 3505.4(c), 3505.4(d), 3507.2, 3507.4, and 3508.2.	I 260		
I 300	3515.1 CONFIDENTIALITY OF RECORDS Each GHMRP shall have written policies governing access to, duplication, of, and release of information from each resident ' s record consistent with D.C. Law 2-137, D.C. Code § 6-1972 and this chapter. This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the confidentiality of all Resident ' s information. The finding includes: It was observed on both 03/20/2008 and 03/21/2008 that all six Resident ' s had their personal habilitation information posted in various open areas throughout the facility. The Program Coordinator was interviewed on 03/21/2008 at 3:48pm regarding this lack of privacy and she responded by removing one of the documents in question from off the wall in the staff office. She further indicated that she was also aware some of the Resident ' s personal information was posted	I 300	3515.1 All postings in the facility that violate resident privacy policy have been removed. The new policies and procedure manual address privacy issues related to resident records and privacy In the future staff will be trained to follow policies and procedures and adhere to privacy.	3/30/08

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I 300	Continued From page 24 throughout the facility and would work to correct that deficient practice. Record review revealed there was no policy presented or on file at the time of survey to substantiate that there was any system in place to address the maintenance of Resident records.	I 300		
I 333	3517.11 ADMISSION POLICIES PROCEDURES No later than ten (10) days after the date of admission, the GHMRP director shall ensure that implementation of the Individual Habilitation Plan is begun for each resident who is admitted with an Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the habilitation and training of its Residents. (Examples: Resident #1 & #2) The finding includes: Record review on 3/21/2008 revealed all six of the residents had either medical or habilitative recommendations that were not being implemented. Examples of the failed implementations are as follows: 1. Resident #1 ' s Psychology Assessment 01-09-08 recommended that the Group Home for Mentally Retarded Persons (GHMRP) implement the revised [behavior support plan] BSP with the following goal and objectives: a. Goal: [Resident #1] will improve her behavior with a reduction in maladaptive incidents. i. Obj#1: [Resident #1] will reduce incidents of	I 333		

PRINTED: 04/04/2008
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I 333	Continued From page 25 non-compliance to 3 (or less) per month for 6 consecutive months. ii. Obj#2: [Resident #1] will reduce the incidents of taking food items given to others to 1 in 6 consecutive months. iii. Obj#3: [Resident #1] will reduce incidents of aggression to 3 (or less) per month for 6 consecutive months. iv. Obj#4: [Resident #1] will reduce incidents of eating inedible/unsanitary items to 0 per month for 6 consecutive months. v. Obj#5: [Resident #1] will reduce incidents of unhygienic practices to 5 (or less) per month for 6 consecutive months. Record review on 3/21/2008 at 4:12pm revealed none of these " revised " recommendations were being implemented. Interview with the facility ' s Program Coordinator revealed she was not aware of these recommendations. 2. Resident #2 ' s Physical Therapy (PT) Quarterly dated 1/3/2008 recommended that the facility purchase ankle weights. Interview with the facility ' s Program Coordinator and the facility ' s direct care staff on 3/21/2008 at 5:01pm revealed there were no " ankle weights " anywhere in the home for Resident #2.	I 333	3517.11 a) i. Objective has been implemented since the inception of Capital Care on 2/1/08. See attachment. ii. Objective #2 was implemented on 2/1/08 ii. Objective #3 was implemented on 2/1/08 iii. Objective #4 was implemented on 2/1/08 iv. Objective #4 was implemented on 2/1/08 V. Objective #5 was implemented on 2/1/08. Program coordinator could not have stated that she was not aware of recommendations as she set up the program books and scheduled BSP training that was completed on A new Physical Therapy assessment was completed 2/7/08 and the exercise commended did not include weight. See attached..	2/1/08 3/21/08
I 334	3517.12 ADMISSION POLICIES PROCEDURES The GHMRP director shall, in the implementation of the Individual Habilitation Plan, consider each recommendation made by the Interdisciplinary Team and consult with professionals or experts	I 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0074	A. BUILDING _____ B. WING _____	R 03/21/2008

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I 334	Continued From page 26 as necessary to ensure that implementation of the Individual Habilitation Plan is accurate. This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the necessary professional oversight in implementing a Resident ' s habilitation plan. (Example: Resident #2) The finding includes: The facility failed to ensure the implementation of an effective system of maintenance and oversight for all six of its residents with regards to the implementation of the Individual Service Plans. An example of the findings was presented below: Resident #2 ' s Occupational Therapy (OT) assessment dated 4/20/2007 identified needs in the areas of dressing, bathing, and functional mobility (transferring from the couch to stand) and tying shoe laces. According to the assessment, the results of the evaluation were shared with the staff and the QMRP. Record review and interview with the Program Coordinator on 3/21/08 5:04pm revealed Resident #2 did not have any habilitative supported in place to help her improve in the areas of dressing, functional mobility and tying her shoe laces. In addition, the Program Coordinator indicated that a new Individual Service Plan was held on 2/8/2008, but the programming objectives that were assigned at that time have not been implemented to date. There was no evidence on file to substantiate that either the original OT	I 334	3517.12 Capital Care assumed the management of the house on 2/1/08. The new Occupational Therapy recommendation from assessment done 2/4/08 are being implemented. At the time of the survey, the OT assessment was not in file. The new OT assessment is now on file. Program coordinator will ensure that all recommendations are carried out in a timely manner. Quality assurance will conduct an audit quarterly to ensure that all recommendation are implemented.	4/1/08

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I 334	Continued From page 27 assessments or the revised recommendations from the 2/8/2008 Individual Service Plan were being implemented as recommended.	I 334		
{I 371}	3519.2 EMERGENCIES Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure all staff had been trained to carry out the provisions and services outlined in the policies and procedures. The finding includes: Record review and interview with the facility ' s Program Coordinator on 3/21/08 at 6:38pm revealed there was no evidence that the facility had ensured the proper and necessary training of its staff. There was no evidence presented or on file at the time of survey to substantiate that the staff had been trained to address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death as required in 3519.1. Interview with the facility ' s Program Coordinator on 3/21/2008 at 4:17pm revealed the staff training log was not available for review at the time of survey. [Reference the citations in the areas of record keeping as cited in 3505.4(a)(1), 3505.4(a)(2), 3505.4(a)(3), 3505.4(a)(4), 3505.4(a)(5), 3505.4(a)(6), 3505.4(a)(7), 3505.4(a)(8), 3505.4(b), 3505.4(c), 3505.4(d), 3507.2, 3507.4, and 3508.2.]	{I 371}	3519.2 All staff have been trained on policies and procedures that address general disaster, missing persons, serious illness or trauma and death. In the future program coordinator will make sure a schedule is in place for all yearly training in policies and procedure. QA will follow up to ensure that all training is completed in a timely manner.	4/30/08

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I 402	Continued From page 28	I 402		
I 402	3520.4 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include an annual health inventory of each resident. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure all Resident ' s were provide with annual assessments as required by this section. (Example: Resident #5) The finding includes: Record review on 3/21/2008 revealed Resident #5 ' s annual Neurology assessment dated 11/21/2007 was not completed due to the physician being away from office. Interview with the facility ' s Program Coordinator on 3/21/2008 at 5:18pm revealed there was no evidence presented or on file at the time of survey to substantiate that this annual assessment was completed as required by this section.	I 402	3520.4 Capital care assumed management of the home on 2/1/08. The earliest neurology appointment that could be made is scheduled for 4/22/08 at Washington Hospital Center. In future, RN will provide oversight to ensure that LPNs are scheduling and completing appointment in a timely manner.	4/22/08
I 404	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that staff	I 404		

PRINTED: 04/04/2008
FORM APPROVED

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I 404	Continued From page 29 received the proper assistance and instruction in meal preparations and provisions. (Example: Resident #1) The finding includes: 1. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended that staff " encourage adequate fluid intake (6-8 cups/day) " . On 3/21/08 at 4:47pm, the facility ' s Program Coordinator (PC) indicated that the GHMRP's staff was taking the necessary measures to ensure that Resident #1 received at least 8oz of fluids during each meal. Record review revealed her most recent lab results indicated she had an abnormally elevated BUN count due to dehydration. At 4:56pm on the same day, the PC presented data that shows staff was documenting that Resident #1 was offered fluids on each meal, but the data being collected did not indicate the amount of cups or fluid ounces per day she ' s consuming. There was no evidence on file or presented during the survey to substantiate that staff had received any training or instructions from the Nutritionist to ensure Resident #1 ' s fluid intake requirements. 2. Resident #1 ' s Nutrition Assessment dated 09-03-07 recommended and supported the current dietary order for " regular [diet] with ground texture, double portions, and increased fiber/liquid nutritional supplement 3 times daily. Observations on 3/20/2008 at 4:49pm revealed Resident #1 ' s food portions were the same as Resident #2 ' s. Resident #1 was not observed to be offered seconds at any time during the evening meal times. There was no evidence on file or presented during the survey to substantiate that staff had received any training or instructions	I 404	3520.6 1. New documentation method is in place to indicate number of fluids consumed. Staff have been trained on hydration. In the future the program coordinator and the nurses will check the fluid intake and do meal monitoring to ensure adequate fluid intake for all individuals. 2. New documentation method is in place to indicate number of fluids consumed. Staff have been trained on hydration. In the future the program coordinator and the nurses will check the fluid intake and do meal monitoring to ensure adequate fluid intake for all individuals.	3/24/08 3/24/08

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I 404	Continued From page 30 from the Nutritionist to ensure Resident #1 ' s recommended " double portions " .	I 404		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure staff were effectively trained to implement a Resident ' s habilitation and treatment plans as recommended. The finding includes: Staff interview and record review on 3/21/2008 revealed the facility failed to ensure the proper and necessary habilitative training and supported as required in the Individual Service Plans of six of its six residents. Interview with the facility ' s Program Coordinator on 3/21/2008 at 4:08pm revealed she would work to ensure that staff are properly trained to implement the habilitation and treatment of its Residents. [Reference the deficient practices cited in 3519.2 and 3520.6]	I 420	3521.1 See 3519.2 and 3520.6	
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client:	I 426		

PRINTED: 04/04/2008
FORM APPROVED

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I 426	Continued From page 31 (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the proper and necessary monitoring of a resident ' s habilitation and treatment as required by this section. (Example: Resident #1) The finding includes: Record review revealed Resident #1 ' s Speech assessment dated 12/27/06 recommended the following: 1. [Resident #1] should continue to receive training via the consultative model to improve her functional communications skills by increasing her sign language vocabulary. 2. Objective: [Resident #1] will produce 4 sign language vocabulary with 75% independence by 12/2007. 3. Short Term Objective: [Resident #1] will produce the manual sign for EAT, DRINK CRACKER, SHOWER with 50% independence for three consecutive months. Record review and interview with the facility ' s Program Coordinator on 3/21/08 4:29pm revealed the " Short Term " objective has not been implemented to date. In addition, there was no evidence this program has been revised since it was written back in 2006 to address Resident #1 ' s lack of progress. The data reflects that she fluctuates between refusing and requiring verbal prompt to complete the task and has been as such since the inception of the program.	I 426	3521.5(c) Capital Care assumed management of home on 2/1/08. All objectives were being done pending review and revisions. The new goals and objectives from 2/8/08 have been implemented. Program coordinator has discontinued objective to produce sign for eat, drink, cracker, shower. In the future Program Coordinator will review objectives on a monthly basis and revise as necessary.	4/1/08

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I 434	3521.7(d) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (d) Dressing (including purchasing, selecting, and access to clothing); This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure a resident received the necessary supports in the area of personal dressing. The finding includes: The facility failed to ensure that its Resident ' s are provided the opportunity to improve their funotional abilities in the area of dressing as cited in 3517.12.	I 434	3521.7(d) Capital Care assumed the management of the house on 2/1/08. The new Occupational Therapy recommendation from assessment done 2/4/08 are being implemented. At the time of the survey, the OT assessment was not in file. The new OT assessment is now on file. Program Coordinator will ensure that all recommendations are carried out in a timely manner. Quality assurance will conduct an audit quarterly to ensure that all recommendation are implemented.	4/1/08
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce	I 437	3521.7(g) See 3521.5(c)	

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I 437	Continued From page 33 the necessary measures to ensure a resident received the necessary supports in the area of communication. The finding includes: The facility failed to ensure that its Resident ' s are provided the opportunity to improve their functional abilities in the area of communication as cited in 3521.5(c).	I 437	3521.7(k) a) i. Objective has been implemented since the inception of Capital Care on 2/1/08. See attachment. ii. Objective #2 was implemented on 2/1/08 ii. Objective #3 was implemented on 2/1/08 iii. Objective #4 was implemented on 2/1/08 iv. Objective #4 was implemented on 2/1/08 V. Objective #5 was implemented on 2/1/08.	2/5/08
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure a resident received the necessary supports in the area of mobility. The finding includes: The facility failed to ensure that its Resident ' s are provided the opportunity to improve their functional abilities in the area of mobility as cited in 3517.11 and 3517.12.	I 441	Program coordinator could not have stated that she was not aware of recommendations as she set up the program books and scheduled BSP training that was completed on A new Physical Therapy assessment was completed 2/7/08 and the exercise commended did not include weight. See attached.. Capital Care assumed the management of the house on 2/1/08. The new Occupational Therapy recommendation from assessment done 2/4/08 are being implemented. At the time of the survey, the OT assessment was not in file. The new OT assessment is now on file. Program coordinator will ensure that all recommendations are carried out in a timely manner. Quality assurance will conduct an audit quarterly to ensure that all recommendation are implemented.	2/5/08
I 445	3521.7(o) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not	I 445		

PRINTED: 04/04/2008
FORM APPROVED

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I 445	Continued From page 34 be limited to, the following areas: (o) Motor and perceptual skills (including balance, posture, and gross and fine motor skills); This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure a resident received the necessary supports in the area of motor skills. The finding includes: The facility failed to ensure that its Resident ' s are provided the opportunity to improve their functional abilities in the area of fine motor skills as cited in 3517.12.	I 445	3521.7(o) Capital Care assumed the management of the house on 2/1/08. The new Occupational Therapy recommendation from assessment done 2/4/08 are being implemented. At the time of the survey, the OT assessment was not in file. The new OT assessment is now on file. Program coordinator will ensure that all recommendations are carried out in a timely manner. Quality assurance will conduct an audit quarterly to ensure that all recommendation are implemented.	2/5/08
I 458	3521.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the provisions of this regulatory requirement. The finding includes: Observation and staff interview on both 3/20/2008 and on 3/21/2008 revealed there was no activity schedule available to staff to ensure timely implementation of habilitative programming and/or community outings. The Quality Assurance specialist could find or present an activity schedule on the afternoon of 3/20/2008	I 458	3521.11 Individuals are given the opportunity to have community outing. Outings are documented, however on the date of survey, the posted activity schedule could not be located. There's a new schedule posted in the home. In future, the home manager will develop activity schedules and make sure they are filed in each individual's records. Program Coordinator will follow up to ensure that there's a schedule and activities are carried out.	4/1/08

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I 458	Continued From page 35 and the Program Coordinator wasn ' t able to present an activity schedule when requested on 3/21/2008.	I 458		
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the accurate documentation and reporting of errors in medication administration. (Example: Resident #3) The finding includes: During the med-pass on the evening of 3/20/2008 the attending nurse crushed Resident #3 ' s medications that were labeled as " do not crush/do not chew " . Record review later revealed there was no physician ' s order on file to support the crushing of the medications. The medications that were crushed are as follows: 1. Depakote 500mg Tabs 2. Nexium 40mg Cap 3. Ferrous Sulfate 325mg Tab 4. Dilantin 100mg Caps The medications were crushed and dissolved with a small can of Nepro (food supplement) and mixed with a crushed mixture of 200mg tabs of Seroquel, 1000mg tab of Vitamin C, 500mg tab of	I 473	3522.4 Resident #3's medications have always been crushed per physician orders. At the time of survey orders were current. See attached Physician orders that were in the home on 3/21/08. Spilled medication is a medication error, and medication nurses have been trained on medication error policy. Nurse entered a late note that indicated notification of RN supervisor and medical director. In future RN will conduct medication pass monitoring monthly to ensure medication nurses are following medication administration procedures.	3/21/08 4/1/08

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I 473	Continued From page 36 Keppra, 125mg tab of Carvedilol, and 30cc of Lactulose. The mixture proved too much for the small can of Nepro and the nurse poured the excess in a small plastic cup which she indicated would be administered " at bedtime. " As she prepared the medication tray to leave the nurses office, she bumped against the door and spilled the can of the medication mixture over the counter on her hand. She wiped up the spillage and administered what was left in the small can to Resident #3. The nursing staff was interviewed on 3/20/2008 at 6:33pm they indicated if a medication was labeled as don ' t crush or chew they would not crush the medication and would ensure the primary care physician would order a liquid substitute if one was needed. The nurses also revealed that the reason Resident #3 ' s medications are crushed was because he did not take well to anything " solid " in his mouth; for that reason they crush his medications. In addition, the nurses indicated that any spillage or destroying of medications would be documented and communicated with the Registered Nurse (RN) and Primary Care Physician. Record review on 3/21/2008 revealed there was no physician ' s order to crush the medications, the nurse failed to document the spillage (MAR or Nursing Notes), the Registered Nurse (RN) or PCP was notified of the spillage and there was nothing presented that would substantiate that Resident #3 was being administered the correct dosages due to the medications being dissolved and split across two separate containers. The facility failed to ensure that medication errors were being communicated to the primary care physician as required by this section.	I 473		

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0074	A. BUILDING _____ B. WING _____	R 03/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CARE	2820 HARTFORD STEET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure client ' s rights as presented in the following citations: The findings include: The facility failed to ensure an effective implementation of client ' s rights to medical and habilitative care as presented in citations 2502.2(b), 3502.16, 3503.3(b), 3504.8, 3504.15, 3515.1, 3517.11, 3517.12, 3521.5(c), 3521.5(d), 3521.5(g), 3521.5(k), 3521.5(o), and 3522.4.	I 500	3523.1 See 2502.2(b), 3502.16, 3503.3(b), 3504.9, 3504.15, 3515.1, 3517.11, 3517.12, 3521.5(c), 3521.5(d), 3521.5(g), 3521.5(k), 3521.5(o) and 3522.4.	